

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the cause of death, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 343. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10658

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centersville</u>		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Centersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				d. STREET ADDRESS <u>Railroad Ave</u>	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER CORKRAN CHANCE</u>			4. DATE OF DEATH Month Day Year <u>Sept 21 1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-14-1913</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Busk Arise</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline &amp; oil</u>		11. BIRTHPLACE (State or foreign country) <u>Centersville Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>James Walter Chance</u>			14. MOTHER'S MAIDEN NAME <u>Virian Bassett</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-9504</u>		17. INFORMANT <u>Margaret J Chance</u> Address <u>Centersville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (c) DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>13 Miss</u> <u>fever</u>					INTERVAL BETWEEN ONSET AND DEATH <u>13 Miss</u> <u>fever</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Centersville</u>	(County) <u>Maryland</u>	(State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-22-60</u>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 24-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centersville</u>		22d. LOCATION (City, town, or county) (State) <u>Centersville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Butler Baiter Bus</u>		ADDRESS <u>Centersville Md</u>		24a. REC'D BY REGISTRAR <u>SEP 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

10677

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10659

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rd # 1 Chestertown</b>		c. LENGTH OF STAY IN 1b <b>lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home - Pondtown</b>		d. STREET ADDRESS <b>RFD # 1 Chestertown, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary Addie</b> Middle <b>Elliott</b> Last		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer and Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Queen Anne Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jarvis Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hemsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-18-6560</b>	
17. INFORMANT <b>Herman Elliott</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Both</b> <b>170X</b> DUE TO <b>Causes of Body Breakdown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> (c) <b>Asphyxia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval BETWEEN ONSET AND DEATH</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1960</b> to <b>Sept 5, 1960</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred on <b>7:00</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Metcalfe</b>		22b. DATE SIGNED <b>9/9/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b>		22d. ADDRESS <b>Pondtown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/8/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Pleasant Cemetery - Pondtown Q.A. Co. Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bennett Wadley</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Farris</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10678

CERTIFICATE OF DEATH

Reg. Dist. No. 10660

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STEVENSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STEVENSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>GROLLMAN</u> Middle <u>GROLLMAN</u> Last		4. DATE OF DEATH <u>September 27</u> Month <u>27</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Leon Rodgin</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Greenspon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry Grollman</u> Address <u>Stevensville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Pulmonary edema</u> 2 hours <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardio-vascular disease</u> (c) <u>arteriosclerosis general hyperension with decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus about 15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sept 27, 1960</u> <u>5 years</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>38</u> , to <u>Sept. 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>September 27, 1960</u> , and that death occurred at <u>7:48</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stevensville Md</u> DATE SIGNED <u>Sept 27, 1960</u>			
ACTUAL SIGNATURE <u>Theodor Sattelmayer</u> M.D.		PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAYER M.D.</u> <u>STEVENSVILLE Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Anshe Emurat</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Feinson &amp; Bros.</u> ADDRESS <u>Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



CERTIFICATE OF DEATH

1934

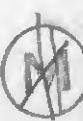
M

*[Faint, illegible handwritten text on a death certificate form, likely bleed-through from the reverse side. The form includes fields for name, age, sex, race, date of death, and cause of death.]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

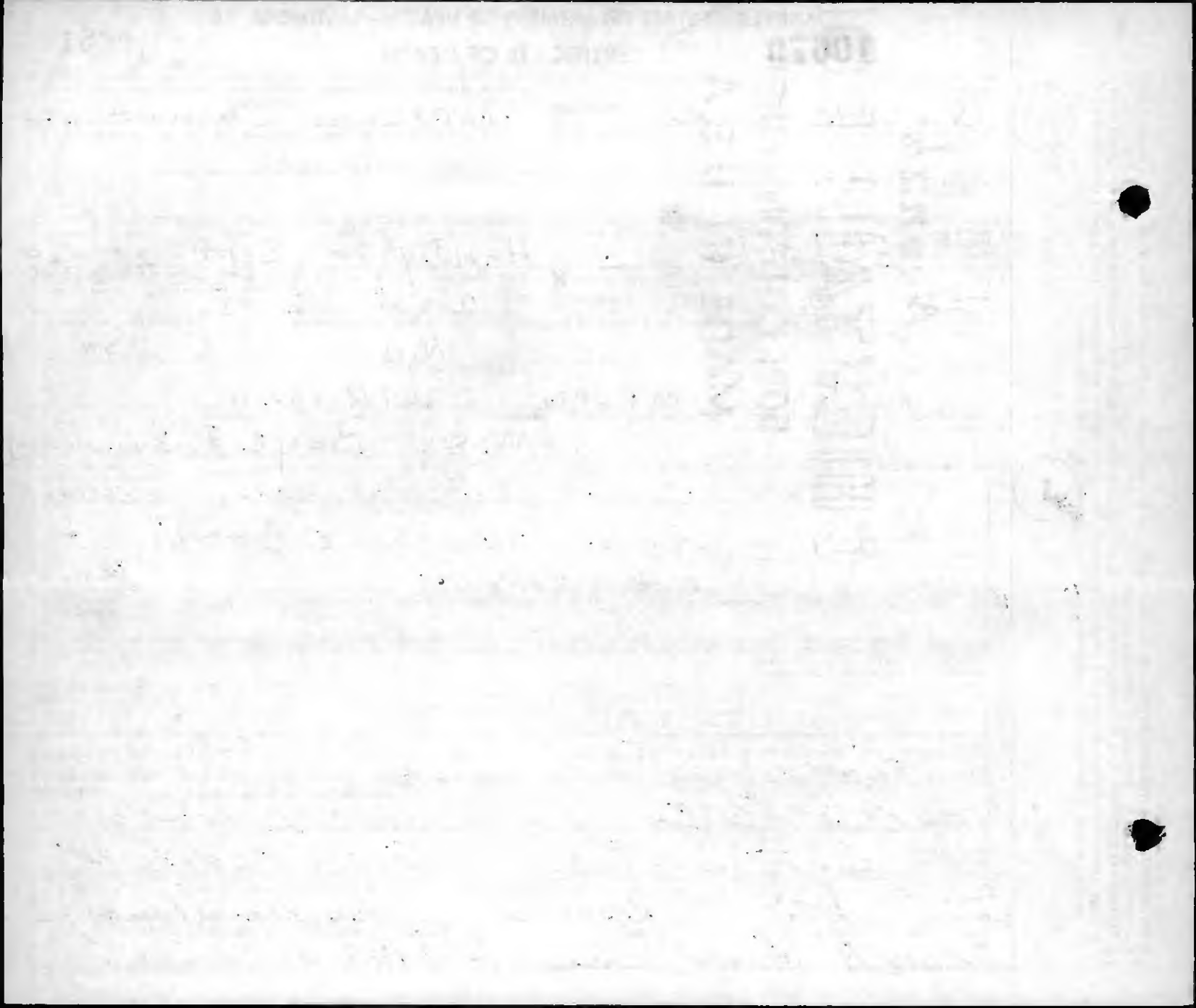
VS A15 (4)  
15M 9/58



X

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
106679										
CERTIFICATE OF DEATH										
Reg. Dist. No. 10661										
1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville (rural)</u>					c. LENGTH OF STAY IN 1b <u>X</u> <u>Centreville (rural)</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>					e. STREET ADDRESS <u>--</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ESTELLA</u> Middle <u>S</u> Last <u>HANDY</u>					4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1960</u>					
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>B.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>about 76</u>		9. AGE (In years last birthday) yrs. <u>76</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>John Simpson</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>MARY BOYCE</u>					
17. INFORMANT <u>Queen Anne</u>					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis Cerebral</u> DUE TO (c) <u>+ Cerebralized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
INTERVAL BETWEEN ONSET OF DEATH <u>10 days</u> <u>years</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 25</u> , 19 <u>60</u> , to <u>Sept 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>60</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>C. R. Boynton</u> M.D.					ADDRESS (Street, city or town, state) <u>104 S Liberty Centreville Md</u>					
PHYSICIAN'S NAME (Type) <u>C. R. Boynton</u>					DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>		<u>Sept 30 / 60</u>		<u>Greenelle</u>		<u>Queen Anne (Rural)</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>					ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	





10680

## CERTIFICATE OF DEATH

Reg. Dist. No.

10662

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville, (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>MARCELLENA JOLLY KILSON</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Celored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stephen C. Jolley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wm. Norton Kilson, Sudlersville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diarrhea Cause, unknown</b> <b>4344</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility, and heart trouble, type unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 4, 1960</b> , to <b>Sept 4, 1960</b> , that I last saw the deceased alive on <b>Sept 4, 1960</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Robert W. Farr</b> M.D. <b>September 4, 1960</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/7/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Marydel, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 13 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneib</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Clinic	
Jan 20, 1945		10:30 AM		Home		J. Smith, M.D.		None	
Signature of Informant		Relationship to Deceased		Signature of Physician		Signature of Registrar		Signature of Coroner	
J. Doe		Son		J. Smith, M.D.		J. Doe		J. Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

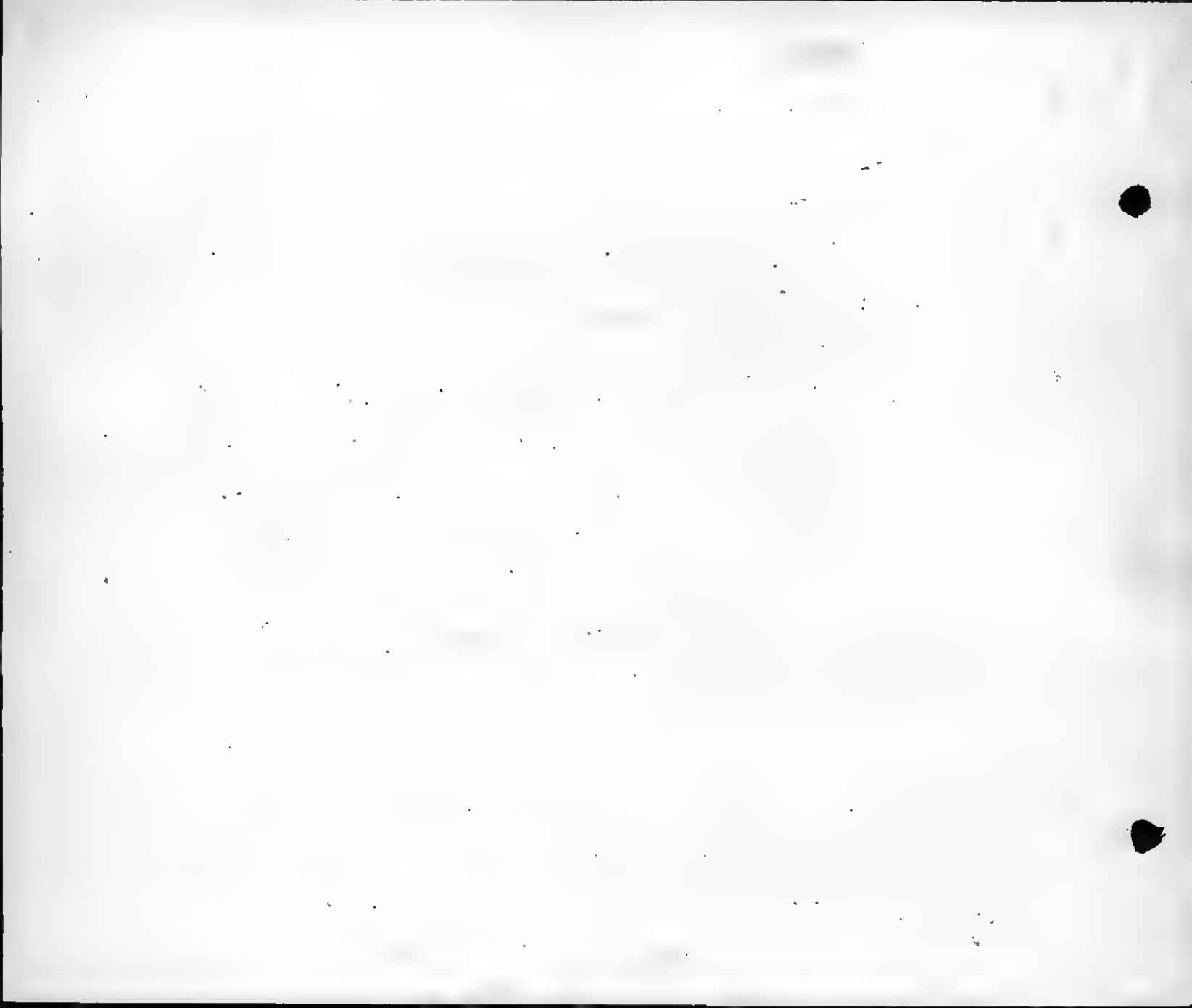
10681

CERTIFICATE OF DEATH

Reg. Dist. No. 10663

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LORETTA</u> Middle <u>P.</u> Last <u>LANE</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15 - 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN F. PORTER</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE PALMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>CHARLES LANE</u> Address <u>CHESTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma abdominal</u> DUE TO <u>carcinoma of small bowel</u> (b) <u>ovary + bladder</u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>resection of small bowel ovary + part of urinary bladder</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>about 1 year</u> <u>1948</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>1948</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 8</u> , 19 <u>60</u> to <u>Sept 18</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Sept. 17</u> , 19 <u>60</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stevensville Maryland</u> DATE SIGNED <u>9/19/60</u> ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D. <u>STEVENSVILLE, MD.</u> PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAYER M.D.</u> <u>STEVENSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 20</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard. Kane Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>DAS 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10664

1. PLACE OF DEATH a. COUNTY <u>Chesapeake</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Chesapeake</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>108 S. Liberty St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>F</u> Last <u>McPHERSON</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 17 - 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor - of Medicine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Practitioner</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas McPheron</u>				14. MOTHER'S MAIDEN NAME <u>Jane Bane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-639</u>		17. INFORMANT <u>Dr. B. B. Hutton</u> Address <u>Chesapeake Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO (b) <u>Cornary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthroscopic Analysis &amp; Reported</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-10 yrs</u> <u>years</u> <u>year</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 17, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. B. Hutton</u>				ADDRESS <u>Chesapeake Md</u>		24a. REC'D BY REGISTRAR <u>SEP 20 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Hutton</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





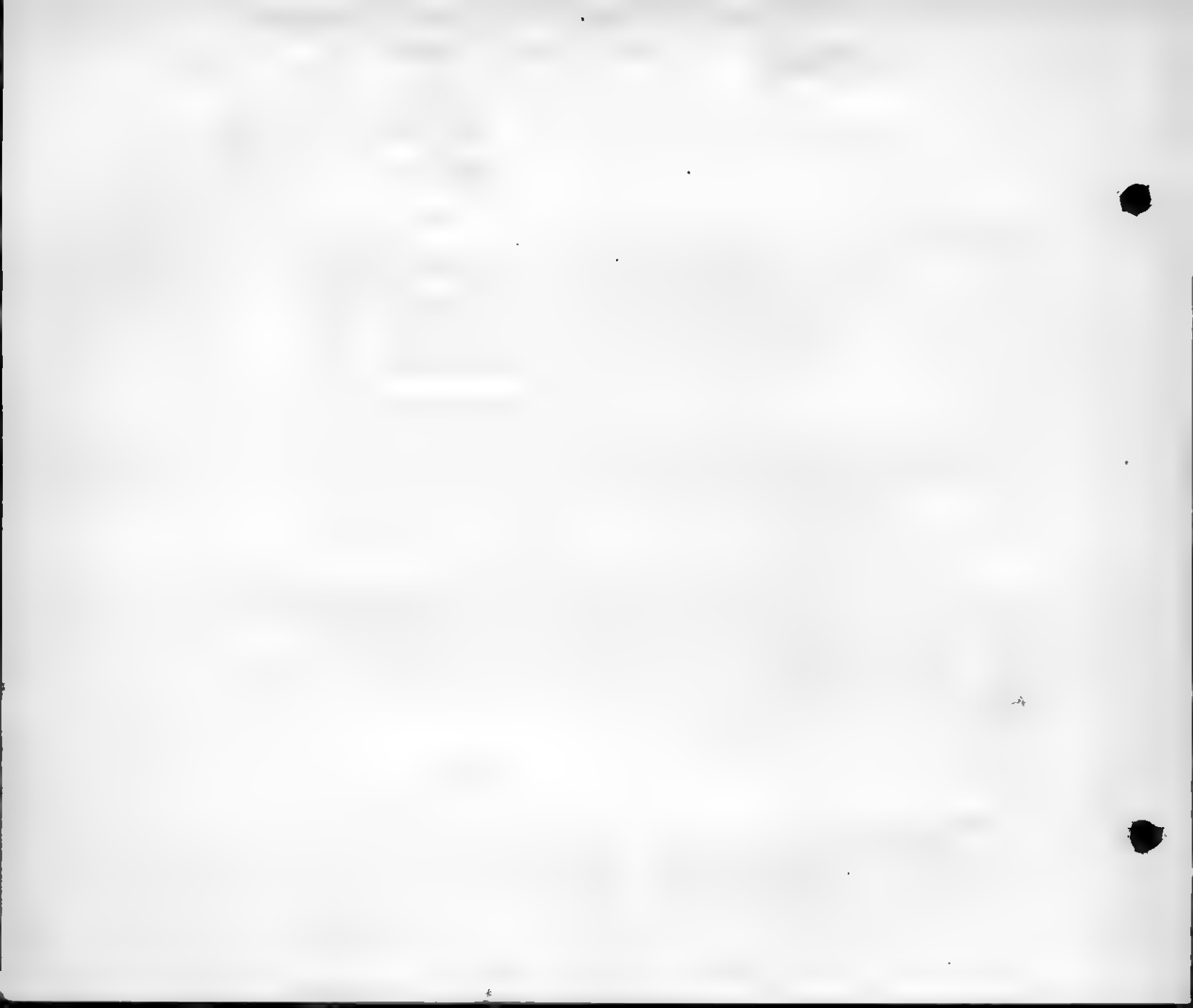
10665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEEN ANNE</u>		c. LENGTH OF STAY IN 1b <u>ALL HIS LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HORACE</u> Middle <u>MUSTARD</u> Last <u>MORGAN</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 18, 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FEED</u>	
11. BIRTHPLACE (State or foreign country) <u>QUEEN ANNE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB EUGENE MORGAN</u>		14. MOTHER'S MAIDEN NAME <u>LIZZIE BARTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>214-32-716</u>	
17. INFORMANT <u>MRS. CARRIE H. MORGAN</u>		Address <u>QUEEN ANNE, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A. H. D</u> <u>20.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis, general</u> DUE TO (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , to <u>9/12/1960</u> , that I last saw the deceased alive on <u>9/15/1960</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11 Fairbairn Ave. Eastport</u> DATE SIGNED <u>  </u> ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 16 - 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hellbore</u>	22d. LOCATION (City, town, or county) (State) <u>Hellbore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Barton</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Clifford S. Howard</u>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the physician be notified by the hospital or attending physician.

VS A15 (4)  
15M 10/57



10675

## CERTIFICATE OF DEATH

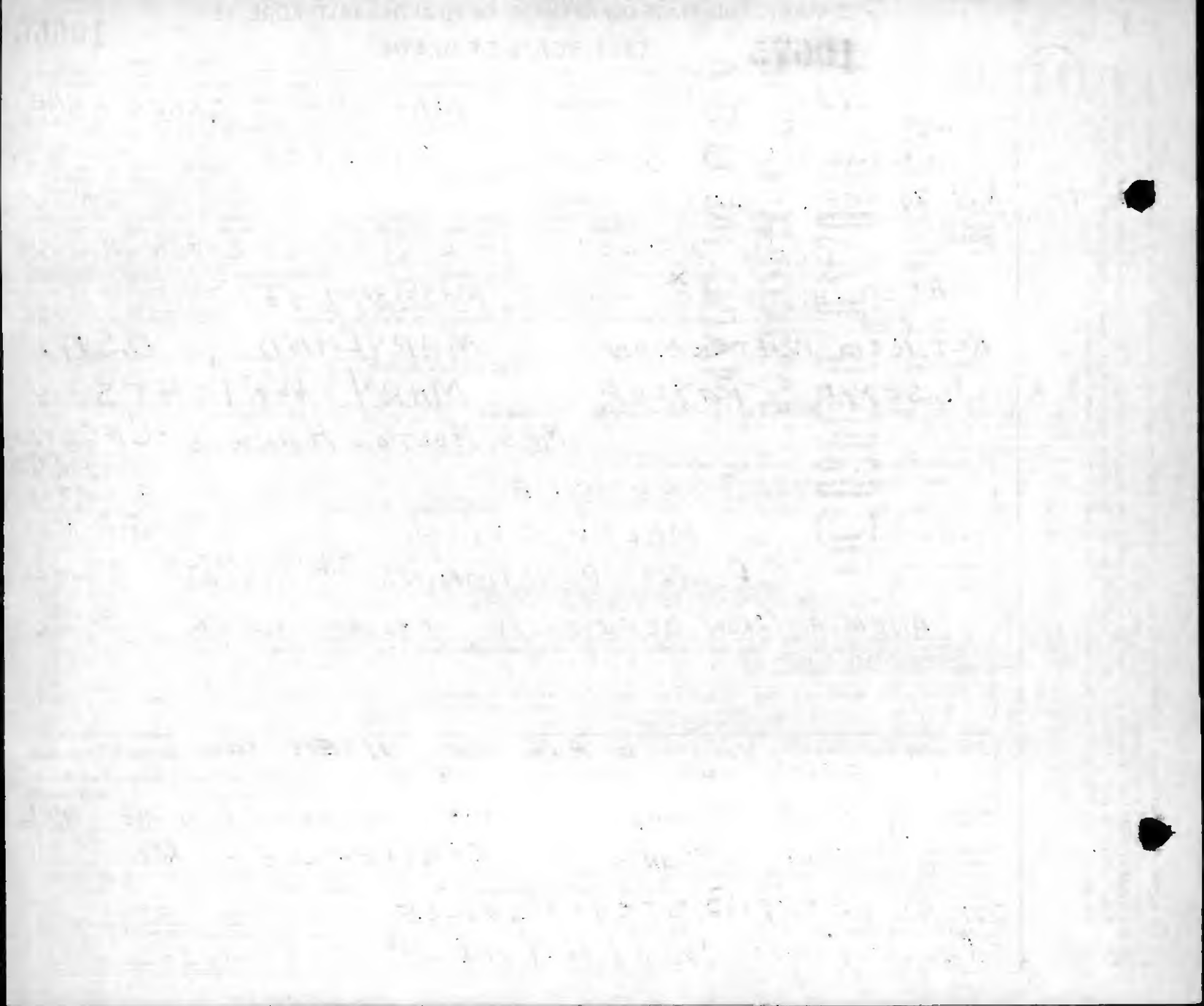
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE'S MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CENTREVILLE</b>		c. LENGTH OF STAY IN 1b <b>5 WEEKS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MRS. M. LOHR'S NURSING HOME</b>		d. STREET ADDRESS <b>CHESTER</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WESLEY</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 MAY 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>MARY WRIGHTSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>MRS. HOLTON HARRIS - CHESTER</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>578X</b> DUE TO <b>MALNUTRITION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>POORLY FUNCTIONING GASTROENTEROSTOMY</b> DUE TO <b>3 WEEKS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA (IRON DEFICIENCY) PYLORIC ULCER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>8-10 MOS.</b>	
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 AUG. 1960</b> to <b>11 SEPT. 1960</b> that I last saw the deceased alive on <b>10 SEPT. 1960</b> and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 CHESTERFIELD AVE. CENTREVILLE, MD.</b> DATE SIGNED <b>9/11/60</b>			
ACTUAL SIGNATURE <b>J. Kent Young</b>		M.D. <b>J. KENT YOUNG</b>	
PHYSICIAN'S NAME (Type) <b>J. KENT YOUNG</b>		ADDRESS <b>CENTREVILLE, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 13</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>Stevensville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar H. Hanel</b>		24a. REC'D BY REGISTRAR <b>SEP 13 '60</b>	
ADDRESS <b>Church Hill Ind.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanel</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58







1000

RECEIVED

1000



DATE: 10/10/10

TO: Mr. J. H. [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]